CHANGE REQUEST FORM
Medical Marijuana Program

Instructions: The Montana Medical Marijuana Act requires any changes made to an application be submitted to the Montana Medical Marijuana Program within 10 days in writing. Please use this form to submit changes. If applicant is a minor (under 18), the custodial parent or legal guardian with responsibility for health care decisions must be listed as the Primary Caregiver, and the information requested on the back of this form must be completed. Please type or print legibly.

QUALIFYING PATIENT INFORMATION (REQUIRED)

NAME (LAST, FIRST, M.I.): _____

DATE OF BIRTH: _____MT DRIVERS LICENSE OR STATE ID #_____SSN_____

MAILING ADDRESS: _____TELEPHONE NUMBER_____

CITY: _____STATE_____ZIP CODE_____EMAIL ADDRESS_____
(optional)

CAREGIVER *(IF APPLICABLE)*

NAME (LAST, FIRST, M.I.): _____

DATE OF BIRTH: _____MT DRIVERS LICENSE OR STATE ID #_____SSN_____

MAILING ADDRESS: _____TELEPHONE NUMBER_____

CITY: _____STATE_____ZIP CODE_____EMAIL ADDRESS_____
(optional)

SIGNATURE AND DATE REQUIRED

QUALIFYING PATIENT SIGNATURE: _____DATE: _____

CAREGIVER SIGNATURE: _____DATE: _____

(OVER)

DECLARATION OF PERSON RESPONSIBLE FOR MINOR

INSTRUCTIONS: Complete all information in order to comply with the registration requirements of the Montana Medical Marijuana Act. This portion is required in addition to the patient application portion if the qualifying patient is under 18 years of age.

1. I am the __Custodial Parent or __Legal Guardian with responsibility for health care decisions for:

_____
MINOR'S NAME

2. The applicant's attending physician has explained to the minor and me the potential risk and benefits of the medical use of marijuana.
3. I consent to the use of marijuana by the applicant for medical purposes.
4. I agree to serve as minor's designated primary caregiver; AND
5. I agree to control the acquisition of marijuana and the dosage and frequency of use by the minor.

NAME (LAST, FIRST, M.I.): _____MALE_____FEMALE_____

DATE OF BIRTH: _____MT DRIVERS LICENSE OR STATE ID #_____SSN_____

MAILING ADDRESS: _____TELEPHONE NUMBER_____

CITY: _____STATE_____ZIP CODE_____EMAIL ADDRESS_____
(optional)

SIGNATURE OF CUSTODIAL PARENT OR LEGAL GUARDIAN REQUIRED: _____

MAIL APPLICATION FORM TO: DPHHS / QUALITY ASSURANCE DIVISION
LICENSURE BUREAU
PO BOX 202953
HELENA MT 59620-2953